

Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Name of Person Receiving Vaccine: Kellie A. Shumack
(First Name, Middle Initial, Last Name)
Date of Birth: 04/25/1967 Social Security Number: 423-02-6638
Phone #: 334.324.4147 Email: Kshumack@aum.edu
Patient Address: 1507 Tara Ln. Montgomery, AL 36117
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: ☒
Ethnicity: Hispanic: _____ Non-Hispanic: ☒ Unspecified: _____
Race: White: ☒ African American: _____ Asian: _____
American Indian: _____ Native Hawaiian: _____ Other: _____

Please answer each question listed below:	Yes	No
1.) Do you have a severe allergy (hypersensitivity) to any component of the vaccine?		X
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		X
3.) Do you have a bleeding disorder or are on a blood thinner?		X
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		X
5.) Do you currently have an acute illness and/or high fever?		X
6.) Are you immunocompromised or on a medication that affects your immune system?		X
7.) Have you received another COVID-19 vaccine?		X
If Yes, Vaccine Name: _____ Date Received: _____		X
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		X

I have read and understand the **2020-2021 COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS** (dated 12/2020). I have had the opportunity to discuss the risk/benefits of the COVID-19 vaccine. I have had the chance to ask questions which were answered to my satisfaction. I hereby consent to receive the COVID-19 vaccine.

Kellie A. Shumack

(Print Name)

Kellie A. Shumack

(Sign Name)

2/12/21

(Date)

-----Staff Use Only-----

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer 6/21	ENC62000	6/21	0.3ml IM	@Delt	2/12/2021 7:33	J. Harvard

ENC62000